ANTHEM BLUE CROSS AND BLUE SHIELD
PROFESSIONAL PROVIDER AGREEMENT
PROVIDER MANUAL

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PLAINTIFF'S EXHIBIT "B"

ANTHEM BLUE CROSS AND BLUE SHIELD
PROFESSIONAL PROVIDER AGREEMENT
PROVIDER MANUAL

SECTION I.

INTRODUCTION

This Provider Manual is a part of and incorporated into the Anthem Blue Cross and Blue Shield Professional Provider Agreement ("Agreement"). This Provider Manual may be updated from time to time in accordance with the terms and conditions of the Agreement.

SECTION II.

QUALITY IMPROVEMENT PROGRAM

ANTHEM conducts an ongoing Provider Quality Improvement Program ("QI Program") designed to promote the delivery of health care to *ANTHEM* Covered Individuals. *PROVIDERS* participating in certain Networks as designated by *ANTHEM* are expected to implement and maintain quality improvement programs in accordance with *ANTHEM*'s QI Program requirements and performance targets, including, but not limited to:

On-site Office Review

All Providers have agreed to comply with on-site office review procedures under the terms and conditions of their Professional Provider Agreement.

Physician office reviews are conducted prior to contracting and biannually thereafter for all Primary Care Providers ("PCP", or "PCPs"), obstetrician/gynecologists, and high volume specialty care physicians. *ANTHEM's* Network Management staff conducts the initial on-site review. A PCP's medical records are reviewed by the regional QI staff to determine if: (1) they meet 80% of the medical record review criteria; and (2) the combined on-site and medical record reviews meet the 80% target. Ob/Gyns and high volume specialists are required to have on-site reviews conducted without review of medical records. Following the review, the *PROVIDER* will receive, at a minimum, a letter that includes the percentage of criteria met and the findings of the review, whether they are positive or require follow-up action.

If the standards are not met, regional QI staff will develop a corrective action plan and present it to *PROVIDER*. Action could include further auditing of medical care at specified intervals, education regarding practices, dissemination of comparative data or standards of care, a meeting with *PROVIDER*, probation or termination of Network participation.

In addition to the general review, medical records with the following diagnoses and procedures are reviewed to determine compliance with minimum disease management and health practice guidelines. The review is conducted according to disease management and preventive health indicators developed by expert resources and clinical staff.

- Well baby care (newborns to 1 year)
- Well child care (15 to 24 months)
- Recurrent otitis media
- Asthma
- Diabetes mellitus
- Normal pregnancy
- Mammography
- Pap Smears
- Cardiovascular Disease

Medical Records

Medical record documentation is essential to the delivery of excellent medical care. Plan strongly encourages *PROVIDER* to comply with the preferred medical record elements (listed below).

PROVIDER's medical records should provide continuity and coordination of care over time, even if several providers are involved. Medical records are evaluated during or after on-site office reviews. The following elements should be documented or considered to ensure a complete medical record:

- Patient identification on each page
- Biographical and personal data
- Dated entries

- Identifies the physician or office staff who made the entries

SECTION II.

QUALITY IMPROVEMENT PROGRAM
continued

- Writing is legible
- Complete problem list
- Complete medication list
- Allergies/adverse reactions to medications prominently noted
- Complete history and physical
- Use of alcohol, drug, and/or tobacco
- Appropriate ordering of lab tests and studies
- Verified review by physician of all lab tests, studies, consults, and other medical reports
- Diagnosis consistent with findings
- Treatment plan consistent with diagnosis
- Follow-up for each plan
- Follow through on problems from previous visits
- Appropriate use of consultants
- Continuity and coordination of care between PCPs and specialty physicians
- Appropriate medical care
- Preventive services completed, such as immunizations, mammograms, and Pap smears
- Appropriate confidentiality of records maintained

*Note: Continuity and coordination of care are assessed by evaluating the extent to which referrals are noted in the primary care chart, specialty referral reports, etc.

SECTION III.

PROVIDER CREDENTIALING STANDARDS

Initial Selection

Providers must complete a standard application for the credentialing process when applying to participate in *ANTHEM*'s managed care networks.

Credentialing Criteria

Providers initially applying to participate in *ANTHEM*'s managed care networks must satisfy criteria for participation.

Each application is reviewed by a credentialing specialist or outsourced to a Credentialing Verification Organization (CVO). The credentialing specialist or CVO reviews the application for completeness and if necessary requests additional information from the provider. After the primary source verification is completed, the credentialing specialist or CVO verifies whether the provider appears to meet the minimum criteria or thresholds, such as education and training requirements, sufficient liability insurance, satisfactory medical malpractice history, etc. If the provider does not meet the established minimum standard, the deficiency or area of concern is noted for review by *ANTHEM*'s credentialing committee. Provider's application status is considered incomplete until all appropriate verifications have been satisfactorily completed.

Criteria Verified from Primary Source

In the initial credentialing process of Providers, *ANTHEM*, or CVO obtains and reviews verifications of the following credentials from primary sources:

- License(s) in the state(s) in which the provider practices
- Primary hospital privileges
- DEA/CSR certification
- Board certification or highest level training/education
- Malpractice insurance
- Professional liability claims history
- Work history is reviewed but not verified with primary sources.

Office Reviews

In addition to the above criteria, PCPs and Ob/Gyns applying for participation as care-managers must successfully pass an office review.

Review by the Credentialing Committee

ANTHEM's Quality Improvement Committee designates a Medical Director to oversee *ANTHEM*'s credentialing program.

Each state or health service area designates a credentialing committee to review the providers applying for participation in ANTHEM's managed care networks and makes recommendations to the Medical Director. After the recommendations are reviewed by the Medical Director the provider is notified in writing of his/her acceptance or denial for participation in the Network(s).

Recredentialing

Providers in *ANTHEM*'s managed care networks are recredentialed at least every two (2) years in order to ensure that Providers continue to meet established credentialing criteria.

SECTION III.

PROVIDER CREDENTIALING STANDARDS
continued

The recredentialing process is very similar to the credentialing process. All PCPs and Ob/Gyns must successfully pass another office review. Also, those specialists who have been identified as high volume must also complete an office review.

All credentials, with the exception of education and training, are once again primary source verified. All appropriate external monitoring agencies are also queried. Information related to customer complaints, clinical reviews, utilization and drug formulary compliance are also incorporated into the review process.
Providers who do not meet the minimum criteria or who are above threshold are identified for special review by the credentialing committee. The credentialing committee makes recommendations on the acceptability of Providers to the Medical Director.

The Medical Director reviews the recommendations and notifies the appropriate network management staff of the acceptance or denial of the Providers.

SECTION IV.

UTILIZATION MANAGEMENT PROGRAM

PROVIDER agrees to abide by the following Utilization Management Program ("UM Program") requirements in accordance with the terms of the Agreement and the Covered Individual's Health Benefit Plan. *PROVIDER* agrees to adhere to the following provisions and provide the information as outlined below, including, but not limited to:

Referrals

As part of the Professional Provider Agreement, *PROVIDER* agrees to refer Covered Individuals to other Network Providers, including specialists and admit to Network hospitals and facilities except:

- in the case of an Emergency and no Network Providers are available
- when required services are not geographically available
- when the Covered Individual refuses to accept your recommendation of referral to another Network Provider.

To obtain a listing of Network Providers, please consult a network directory. Directories are mailed to all Network Providers.

Medical Management Authorizations

Any PCP in one of Plan's HMO or Health Insuring Corporation ("HIC") or Point-of-Service Programs is responsible for initiating the referral process for their Covered Individuals who have illnesses or injuries which require the services of a Specialty Care Physician (SCP).

PCPs should refer Covered Individuals to participating SCPs (or facilities) when they are unable to provide the required services and when consistent with sound medical judgment. It is the PCP's responsibility to obtain authorization from the utilization management unit PRIOR to making the referral to ensure the Covered Individual's benefits include coverage for the service. It is the SCP's responsibility to ensure that authorization has been obtained by the PCP prior to rendering services.

Please call the appropriate utilization management unit to authorize services so that the Covered Individual will not be responsible for payment of all or part of the charges for the service.

Unless otherwise stated in the Covered Individual's Health Benefit Plan, *PROVIDER* should not authorize Covered Individual self-referrals to specialists or facilities. When a Covered Individual self-refers, Covered Individuals participating in a Point-of-Service program will receive the alternate (lower) level of benefits for Covered Services. Covered Individuals participating in a HMO/HIC program are responsible for ALL charges incurred for services which are not authorized by the PCP.

The utilization management authorization is limited to the specific SCP, facility, condition, dates of service, length of time and number of visits stated in the written authorization notification that is mailed to the PCP, SCP and/or Covered Individual.

Changes regarding authorized services or rescheduled SCP/facility appointments should be processed with the utilization management staff which may avoid inappropriately denied claims to the Covered Individual.

Referrals to Specialty Care Physicians

As the gatekeeper for the Covered Individual's health care needs, the PCP has agreed to refer Covered Individuals to participating SCPs when medically indicated. If the Network does not have the necessary specialist in-network, the utilization management unit may authorize services to a non-network provider. In situations such as this, the Covered Individual will receive maximum benefits. Out-of-network authorizations can only be approved by the appropriate utilization management unit.

SECTION IV.

UTILIZATION MANAGEMENT PROGRAM
continued

Please note: Covered Individuals may decide to utilize an out-of-network physician when a Network Provider is available and receive the alternate (lower) level of benefits. For each condition, the PCP may elect to use one of two referral options:

- Consult only
- Consult and treat with Plan approval

The intent of these programs is to pre-certify Medical Necessity of all inpatient admissions based on nationally recognized criteria. Then, once the admission is pre-certified, an approved length of stay is established based on the admitting diagnosis, the Covered Individual's condition, signs and symptoms, and the plan of treatment.

The admission will not be certified (under the terms of the Covered Individual's Health Benefit Plan) if *ANTHEM* determines that the admission is not Medically Necessary. However, the Covered Individual may elect to be admitted without receiving certification. Then, coverage for the care will be subject to reduced benefits associated with the program, and the Covered Individual will be responsible for the appropriate hospital bill balances.

Please remember that there are some pre-certification programs in which the *PROVIDER* is responsible for this procedure; others allow the Covered Individual to initiate the process.

In either case, if you have or accept the responsibility for obtaining pre-certification, please follow-up since some programs impose a penalty upon the Covered Individual or *PROVIDER* for failure to complete the process.

On-Site Case Management

The hospital's Utilization Review (UR) staff is responsible for monitoring the stay and treatment, helping to ensure the efficient use of services and resources; and evaluating alternative, available outpatient treatment options.

Re-certification and extending the stay are also based on Medical Necessity.

If more inpatient care is needed beyond the initial days certified, the UR staff should contact the *ANTHEM* utilization management staff to give discharge information or information to extend the stay.

Utilization Statistics Information

On occasion, *ANTHEM* may request utilization statistics for disease management purposes by either diagnosis or CPT code. This may include:

- Patient name
- Patient identification number
- Date of service or date specimen collected
- Physician name and /or identification number
- Value of test requested or any other pertinent information *ANTHEM* deems necessary.

This information will be provided by *PROVIDER* to Plan at no charge to *ANTHEM*.

Failure to Comply With Utilization Management Program

PROVIDER acknowledges that Plan may apply monetary penalties as a result of *PROVIDER*'s failure to provide notice of admission as required under this Agreement, or for *PROVIDER*'s failure to fully comply with and participate in any cost management procedures and/or utilization management activities.

SECTION V.

WORKERS' COMPENSATION PROGRAM

OHIO or INDIANA

If *PROVIDER* is participating in Plan's Workers' Compensation Program or Network, and is rendering Covered Services to a Covered Individual whose workers' compensation Claim will be filed in the State of Ohio or State of Indiana, *PROVIDER* shall comply with the following Workers' Compensation Program Requirements:

Workers' Compensation Program Requirements

1. A Primary Treatment Provider's premises/offices must have walk-in capabilities.

2. *PROVIDER* shall see a Covered Individual within forty-five (45) minutes of the individual's arrival at his/her office. If it is not possible to meet this standard at any time, a member of the office staff should use their best effort to telephone the client contact person to inform him/her of the delay.

3. *PROVIDER* shall complete a return to work/medical treatment report on every Covered Individual's visit.

4. *PROVIDER* shall fax to the Workers' Compensation Program account representative, a legible, completed copy of all Workers' Compensation Program medical treatment reports, first report of injury reports, or the equivalent, within twenty-four (24) hours after the Covered Individual's appointment.

5. In considering each Covered Individual's return to work or restriction from work, *PROVIDER* shall indicate, on the Workers' Compensation Program medical treatment report, all necessary follow-up appointments (date and time if possible), rehabilitation requirements, work restrictions, and length of restrictions.

6. *PROVIDER* and his/her staff shall communicate, in the medical treatment report, to Workers' Compensation Program claims representative, any problems or potential problems encountered when dealing with Covered Individuals.

7. *PROVIDER* or his/her staff shall communicate relevant changes in services, policies, procedures, locations, names, office hours, etc. to Workers' Compensation Program in a timely manner.

8. *PROVIDER* or his/her clinical staff shall respond in a timely manner to the client, nurse, manager, and service representative of Plan or its designee to inquiries regarding Covered Individuals.

9. *PROVIDER* and his/her staff shall be receptive to communication from Workers' Compensation Program nurse manager, training, orientations, and necessary adjustments to Workers' Compensation Program protocols and standards.

Workers' Compensation Program Utilization Management Requirements

1. Except for Emergencies, *PROVIDER* shall admit Covered Individuals only at hospitals that are Network Providers, unless an exception is granted by Plan, its designee or the appropriate state's workers' compensation agency. All non-Emergency admissions require prior written approval by Plan or its designee unless waived by Plan or its designee.

SECTION V.

WORKERS' COMPENSATION PROGRAM
continued

2. Admission authorization and length of stay by diagnosis or procedure shall be established on a pre-admission basis, using guidelines acceptable to the appropriate Plan Workers' Compensation Program and the appropriate state's workers' compensation agency. Extensions or exceptions may be granted on a case-by-case basis by Plan, its designee and the appropriate state's Workers' Compensation Program agency. ***Indiana only*** - *PROVIDER* shall notify Plan or its designee of any non-Emergency inpatient admission prior to the admission. *PROVIDER* shall notify Plan or its designee of any Emergency inpatient admission within twenty-four (24) hours of admission.

3. Radiology and laboratory facilities that are Network Providers must be used for all outpatient radiology and laboratory work which are not performed in your office. If performed in your office, the fee for the service may not exceed the fee which Plan has negotiated with Network Provider radiology and laboratory facilities.

4. Non-Emergency surgery must be performed on the day of admission, except in the case of unusual or unforeseen circumstances, as approved by Plan or its designee.

5. Generic drugs shall be prescribed when generic bio-equivalent substitutes are available; provided however, that required use of generic drugs shall be limited to those produced by major US manufacturers for which the effectiveness of the drug has been demonstrated. Where over-the counter medications are medically appropriate, you shall use those in lieu of prescribing federal legend drugs.

6. Specific non-Emergency outpatient diagnostic and/or therapeutic procedures require approval from Plan or its designee. ***Indiana only*** - *PROVIDER* shall notify Plan or its designee of non-Emergency outpatient diagnostic and/or therapeutic procedures prior to performance of such procedures.

COMMONWEALTH OF KENTUCKY

If *PROVIDER* is participating in Plan's Workers' Compensation Program or Network, and is rendering Covered Services to a Covered Individual whose Workers' Compensation Claim will be filed in the Commonwealth of Kentucky, *PROVIDER* shall comply with the following Workers' Compensation Program Requirements:

Workers' Compensation Program Requirements

1. As a gatekeeper, *PROVIDER* agrees to the following:

   a. *PROVIDER* shall schedule the initial appointment for the Covered Individual within twenty-four (24) hours from the time the phone call is placed *PROVIDER*'s office.

   b. *PROVIDER* shall see the Covered Individual within forty-five (45) minutes of the individual's arrival at his/her office. If it is not possible to meet this standard at any time, a member of the office staff should use their best effort to telephone the client contact person to inform him/her of the delay.

   c. *PROVIDER* shall retain a copy of the employee information form and complete the treatment plan report for the Covered Individual. *PROVIDER* shall evaluate the Covered Individual and decide the appropriate treatment option. The four (4) suggested options for treatment are: (1) return the Covered Individual to work; (2) maintain Covered Individual under *PROVIDER's* care; (3) refer Covered Individual to a specialist provider; or (4) refer the Covered Individual to rehabilitation. The aforementioned treatment options are only guidelines. *PROVIDER* has the ultimate responsibility for the Covered Individual's care.

SECTION V.

WORKERS' COMPENSATION PROGRAM
continued

d. *PROVIDER* shall fax the treatment report within twenty-four (24) hours of the Covered Individual's appointment.

e. *PROVIDER* or his/her clinical staff will respond in a timely manner to the client, nurse, manager, and service representative of Plan or its designee to inquiries regarding Covered Individuals.

f. If it appears that the Covered Individual will miss more than five (5) days from work or if it appears that the Covered Individual's treatment will be complex and involve a referral to other Network Providers, *PROVIDER* shall check the box at the bottom of the treatment report form to indicate that Plan case management should become involved.

2. As a specialist, *PROVIDER* agrees to the following:

a. *PROVIDER* shall schedule the initial appointment for the Covered Individual within forty-eight (48) hours from the time the phone call is placed *PROVIDER*'s office.

b. *PROVIDER* shall see the Covered Individual within forty-five (45) minutes of the individual's arrival at his/her office. If it not possible to meet this standard at any time, a member of the office staff should use their best effort to telephone the client contact person to inform him/her of the delay.

c. In considering each Covered Individual's return to work or restriction from work, PROVIDER shall indicate on the Workers' Compensation Program medical treatment report, all necessary follow-up appointments (date and time if possible), rehabilitation requirements, work restrictions, and length of restrictions.

d. After the Covered Individual's initial visit, *PROVIDER* shall complete the medical treatment report and Fax it to the Workers' Compensation Program representative within twenty (24) hours after the Covered Individual's appointment.

e. Except for Emergencies, *PROVIDER* shall call the Workers' Compensation Program case manager for authorization and *PROVIDER* shall admit Covered Individuals only at hospitals that are Network Providers, unless an exception is granted by Plan, its designee or the appropriate state's workers' compensation agency.

Workers' Compensation Program Utilization Management Requirements

1. Except for emergencies, *PROVIDER* shall admit Covered Individual only at hospitals that are Network Providers, unless an exception is granted by Plan, its designee or the appropriate state's Workers' Compensation agency. All non-emergency admissions require prior written approval by Plan or its designee unless waived by Plan or its designee.

2. Admission authorization and length of stay by diagnosis or procedure shall be established on a pre-admission basis, using guidelines acceptable to the appropriate Plan Workers' Compensation program and the appropriate state's workers compensation agency. Extensions or exceptions may be granted on a case-by-case basis by Plan, its designee and the appropriate state's workers compensation agency.

3. Radiology and laboratory facilities that are Network Providers must be used for all outpatient radiology and laboratory work which are performed in your office. If performed in your office, the fee for the services may not exceed the fee which Plan has negotiated with the Network Provider radiology and laboratory facilities.

SECTION V.

WORKERS' COMPENSATION PROGRAM
continued

4. Elective surgery must be performed on the day of admission, except in the case of unusual or unforeseen circumstances, as approved by Plan or its designee.

5. Generic drugs shall be prescribed when generic bio-equivalent are available; provided however, that required use of generic drugs shall be limited to those produced by major US manufacturers for which the effectiveness of the drug has been demonstrated. Where over-the-counter medication are medically appropriate, you shall use those in lieu of prescribing federal legend drugs.

6. Specific non-Emergency outpatient diagnostic and/or therapeutic procedures require approval from Plan or its designee.

7. Except in the event of an Emergency, if *PROVIDER* recommends inpatient or outpatient surgery, the physician must call the Plan case manager at (800) 444-9042 for authorization. The Plan case manager will review the status of the case, diagnostic findings, treatment alternative and protocols. The Plan case manager will discuss the case with the Medical Director and/or medical consultants, if necessary. Plan will approve the surgery if it is determined to be Medically Necessary. The decision to deny a surgery will only be made by the Medical Director.

PROVIDER agrees to participate in the applicable grievance or appeal procedure established by the applicable Plan Workers' Compensation Program or Network regarding Medical Necessity issues and non-clinical issues. The appeals procedures for Claims filed in the State of Ohio, State of Indiana, or Commonwealth of Kentucky are set forth below.

Workers' Compensation Grievance Procedure

The following grievance process and procedure shall be used by *PROVIDER* to resolve a dispute relative to Workers' Compensation Claims filed in the State of Indiana or Commonwealth of Kentucky.

1. *PROVIDER* shall submit a written complaint or grievance to Plan within thirty (30) days of the date of the occurrence of the event giving rise to the dispute.

2. Plan shall render a written decision within thirty (30) days of receipt of *PROVIDER*'s written complaint or grievance.

3. In the event *PROVIDER* is dissatisfied with Plan's decision regarding a claim filed for services rendered in the Commonwealth of Kentucky, *PROVIDER* may apply for review by an administrative law judge by filing a request for resolution within thirty (30) days of the date of Plan's final decision.

The following grievance process and procedure shall be used by a *PROVIDER* to resolve a dispute relative to workers' compensation Claims filed in the State of Ohio.

1. Level 1: *PROVIDER* shall submit written documentation of a disputed issue to Plan. Plan shall review the documentation and render a written decision to *PROVIDER*. In the event *PROVIDER* is not satisfied with Plan's decision regarding the issue, *PROVIDER* has seven (7) days to submit a written request to Plan for a Level 2 review.

SECTION V.

WORKERS' COMPENSATION PROGRAM
continued

2. Level 2: Upon receipt of *PROVIDER's* request for a Level 2 review, Plan shall review any information submitted by *PROVIDER* and render a written decision to *PROVIDER.*

   For a dispute relative to a Claim regarding Covered Individuals employed by a state-funded employer, Plan has twenty-one (21) days to complete the Level 1 and Level 2 reviews referenced above. For a dispute relative to a Claim regarding Covered Individuals employed by a self-funded employer, Plan has thirty (30) days to complete the Level 1 and Level 2 reviews referenced above.

3. Level 3: If the dispute relates to a Claim regarding a Covered Individual employed by a state-funded employer and *PROVIDER* is not satisfied with Plan's decision at Level 2, *PROVIDER* may appeal the issue to the Bureau of Workers' Compensation by submitting a written request to the Bureau within seven (7) days of receipt of Plan's Level 2 decision.

If the dispute relates to a Claim regarding a Covered Individual employed by a self-funded employer and *PROVIDER* is not satisfied with Plan's decision at Level 2, *PROVIDER* may appeal this issue to the Industrial Commission by submitting a written request to the Industrial Commission.

Each party to this Agreement warrants that it has full power and authority to enter into this Agreement and the person signing this Agreement on behalf of either party warrants that he/she has been duly authorized and empowered to enter into this Agreement.

THE EFFECTIVE DATE OF THIS AGREEMENT IS: **JANUARY 1, 2001.**

PROVIDER PHYSIATRIST ASSOCIATES OF YOUNGSTOWN, INC.

By: _____ 12-18-00
Name Date

Printed: ANTHONY N. PANUSZKA, MD OWNER
Name Title

Address: 1419 BOARDMAN-CANFIELD RD YOUNGSTOWN OH 44512
Street City State Zip

Tax Identification Number (TIN) 34-1653829

Community Insurance Company d/b/a
Anthem Blue Cross and Blue Shield

By: _____ 12/20/2000
Name Date

Printed: Anthony L. Firmstone, CHE Executive Director
Name Title

Address: 2400 Market Street Youngstown, Ohio 44507
Street City State Zip

SPECIFIC PROVISIONS ATTACHMENT
TO THE
ANTHEM BLUE CROSS AND BLUE SHIELD
PROFESSIONAL PROVIDER AGREEMENT

This is a Specific Provisions Attachment to the Anthem Blue Cross and Blue Shield Professional Provider Agreement (the "Agreement"), entered into by and between *ANTHEM* and *PROVIDER* and is incorporated into the Agreement. These provisions are specific to the individual states and are required either by Plan, by statute, or by regulation.

OHIO SPECIFIC PROVISIONS

The following provisions are required terms and conditions for certain Health Benefit Plans that are issued in the State of Ohio.

Effective October 1, 1998, the following Emergency definition shall apply to all Health Maintenance Organization/Health Insuring Corporation (HMO/HIC) Health Benefit Plans issued in the State of Ohio, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan.

1.11 "Emergency" or "Emergency Services" is defined as a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following: (1) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

The following Medical Necessity definition shall apply to all Health Benefit Plans issued in the State of Ohio, unless otherwise set forth by statute, regulation or the Covered Individual's Health Benefit Plan.

1.14 "Medically Necessary" or "Medical Necessity", unless otherwise set forth in the Health Benefit Plan or as otherwise required by statute or by regulation, means that a Health Service is compensable, as determined by *ANTHEM* or another entity with responsibility for medical management, for the treatment of an injury, sickness, or other health condition and is: (1) appropriate and consistent with the diagnosis or symptoms, and consistent with accepted medical standards; (2) not chiefly custodial in nature; (3) not investigational, experimental or unproven; (4) not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment and as to institutional care, cannot be provided in any other setting, such as a physician's office or the outpatient department of a hospital without adversely affecting the patient's condition; and (5) not provided only as a convenience to the Covered Individual or professional provider or health care facility.

The following Statutorily Defined Terms provision shall apply to all HMO/HIC Health Benefit Plans issued in the State of Ohio, unless otherwise set forth by statute, regulation or the Covered Individual's Health Benefit Plan.

2.18 Statutorily Defined Terms. Those terms used in this Agreement and that are defined by O.R.C. §1751.01 et. seq., shall be construed in a manner consistent with the definitions in O.R.C. §1751.01 et. seq.

The following Continuance of Care-Insolvency provision shall apply to all HMO/HIC Health Benefit Plans issued in the State of Ohio, unless otherwise set forth by statute, regulation or the Covered Individual's Health Benefit Plan.

3.14 Continuance of Care-Insolvency. In the event of the Plan's insolvency or other cessation of operations, *PROVIDER* agrees to continue to provide Covered Services to Covered Individuals as needed to complete Medically Necessary procedures commenced but unfinished at the time of Plan's insolvency or other cessation of operations. The completion of a Medically Necessary procedure commenced but unfinished at the time of the Plan's insolvency or cessation of operations includes the rendition of all Covered Services that constitute Medically Necessary follow-up care for that procedure. If a Covered Individual is receiving Medically Necessary inpatient care at a hospital or facility at the time of Plan's insolvency or other cessation of operations, *PROVIDER* agrees to continue to provide Covered Services to Covered Individuals as needed to complete Medically Necessary care until the Covered Individual is discharged from the hospital or facility or until there is a determination by the Covered Individual's attending physician that inpatient care

is no longer medically indicated for the Covered Individual. However, nothing in this provision precludes Plan from engaging in utilization review as described in the Covered Individual's Health Benefit Plan. No provider is required to continue to provide any Covered Services after the occurrence of any of the following: (1) the end of the Covered Individual's period of coverage for which the premium has been paid; (2) the end of the thirty (30) day period following the entry of a liquidation order under Chapter 3903 of the Revised Code; (3) the Covered Individual obtains equivalent coverage with another Health Insuring Corporation or insurer, or the Covered Individual's employer obtains such coverage; (4) the Covered Individual or the Covered Individual's employer terminates coverage under the contract; and (5) a liquidator effects a transfer of the Plan's obligations under the contract under division (A) (8) of Section 3903.21 of the Revised Code. This provision shall survive termination of this Agreement, regardless of the reason for termination, including insolvency of the Plan, and shall be for the benefit of Covered Individuals.

The following Statutory Responsibility provision applies to all HMO/HIC Health Benefit Plans issued in the State of Ohio, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan.

8.20 Statutory Responsibility. *ANTHEM* and/or Plan has statutory responsibility to monitor and oversee the offering of Covered Services to Covered Individuals.

COMMONWEALTH OF KENTUCKY SPECIFIC PROVISIONS

The following provisions are required terms and conditions for certain Health Benefit Plans that are issued in the Commonwealth of Kentucky.

The following Emergency definition shall apply to all Health Benefit Plans issued in the Commonwealth of Kentucky, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan.

1.11 "Emergency" or "Emergency Services" is defined as a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson could reasonably expect the absence of immediate medical attention to result in any of the following: (1) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions, "Emergency" means: (1) a situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or (2) a situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

The following Medical Necessity definition shall apply to all Health Benefit Plans issued in the Commonwealth of Kentucky, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan.

1.14 "Medically Necessary" or "Medical Necessity" unless otherwise set forth in the Health Benefit Plan, means a Health Service furnished by a provider that is required to identify or treat the Covered Individual's condition, illness or injury and which the Plan determines is: (1) consistent with the symptom or diagnosis and treatment of the Covered Individual's condition, disease, ailment, or injury; (2) appropriate with regard to standards of good medical practice; (3) not solely for the convenience of the Covered Individual or provider; and (4) the most appropriate supply or level of service which can be safely provided to the Covered Individual. When applied to the care of an inpatient, it means that the Covered Individual's medical symptoms or conditions require that the services cannot be safely provided to the Covered Individual as an outpatient.

Provision 2.18 - Statutorily Defined Terms is not applicable to services rendered to Covered Individuals enrolled in Health Benefit Plans issued in the Commonwealth of Kentucky, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan.

Provision 3.14 - Continuance of Care-Insolvency is not applicable to services rendered to Covered Individuals enrolled in Health Benefit Plans issued in the Commonwealth of Kentucky, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan.

Provision 8.20 - Statutory Responsibility is not applicable to services rendered to Covered Individuals enrolled in Health Benefit Plans issued in the Commonwealth of Kentucky, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan.

STATE OF INDIANA SPECIFIC PROVISIONS

The following provisions are required terms and conditions for certain Health Benefit Plans that are issued in the State of Indiana.

The following Emergency definition shall apply to all HMO Health Benefit Plans that are issued in the State of Indiana, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan.

1.11 "Emergency" or "Emergency Services" is defined as a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following: (1) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

The following Medical Necessity definition shall apply to all Health Benefit Plans issued in the State of Indiana, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan.

1.14 "Medically Necessary" or "Medical Necessity", unless otherwise set forth in the Health Benefit Plan or as otherwise required by statute or by regulation, means that a Health Service is compensable, as determined by *ANTHEM* or another entity with responsibility for medical management, for the treatment of an injury, sickness, or other health condition and is: (1) appropriate and consistent with the diagnosis or symptoms, and consistent with accepted medical standards; (2) not chiefly custodial in nature; (3) not investigational, experimental or unproven; (4) not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment and as to institutional care, cannot be provided in any other setting, such as a physician's office or the outpatient department of a hospital without adversely affecting the patient's condition; and (5) not provided only as a convenience to the Covered Individual or professional provider or health care facility.

Provision 2.18 – Statutorily Defined Terms is not applicable to services rendered to Covered Individuals enrolled in Health Benefit Plans issued in the State of Indiana, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan.

The following Continuation of Care-Termination provision shall apply to all Health Benefit Plans issued in the State of Indiana, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan.

3.13 Continuation of Care-Termination. In the event that this Agreement is terminated for any reason other than the grounds set forth in the Termination With Cause provision of the Agreement, a Covered Individual may elect to continue to receive care from *PROVIDER* for a period of time as set forth below following termination of this Agreement. Such continuation period shall run for up to sixty (60) days following termination, or, if *PROVIDER* is providing pregnancy-related care to a Covered Individual who is in her third trimester of pregnancy at the time this Agreement terminates, throughout the term of that pregnancy. During this continuation period, *PROVIDER* shall continue to provide care to those Covered Individuals who have elected continuation in compliance with all provisions of this Agreement and of any amendments, attachments, and incorporated documents hereto. Such compliance shall include without limitation acceptance of the applicable Anthem Rate as required in the Payment in Full provision of the Agreement and forbearance from balance billing as required in the Hold Harmless provision of the Agreement.

Provision 3.14 - Continuance of Care-Insolvency is not applicable to services rendered to Covered Individuals enrolled in Health Benefit Plans issued in the State of Indiana, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan.

Provision 8.20 - Statutory Responsibility is not applicable to services rendered to Covered Individuals enrolled in Health Benefit Plans issued in the State of Indiana, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan.

Each party to this Attachment warrants that it has full power and authority to enter into this Attachment and the person signing this Attachment on behalf of either party warrants that he/she has been duly authorized and empowered to enter into this Attachment.

THIS ATTACHMENT IS EFFECTIVE ON: **JANUARY 1, 2001.**

PROVIDER PHYSIATRIST ASSOCIATES OF YOUNGSTOWN, INC.

By: _____ 12-12-00
Name Date

Printed: ANTHONY N. PANUSKA, M.D. OWNER
Name Title

Address: 1419 BOARDMAN-CANFIELD RD YOUNGSTOWN, OH 44512
Street City State Zip

Tax Identification Number (TIN) 34-1052829

Community Insurance Company d/b/a
Anthem Blue Cross and Blue Shield

By: _____ 12/20/2000
Name Date

Printed: Anthony L. Firmstone, CHE Executive Director
Name Title

Address: 2400 Market Street Youngstown, Ohio 44507
Street City State Zip

Anthem Blue Cross and Blue Shield
2400 Market St.
P.O. Box 2709
Youngstown, OH 44507-0709

Anthem

March 19, 2001

Anthony N. Pannozzo, M.D.
748 Boardman-Canfield Rd.
Boardman, OH 44512

Dear Dr. Pannozzo:

Thank you for your interest in Anthem Blue Cross and Blue Shield's Community Choice (POS), Community Preferred Health Plan (CPHP), Preferred Medical Plan (PMP), Anthem Senior Advantage (ASA), Blue Access (*future* Tristate HMO-PPO), Blue Preferred-Option Plan (*future* Tristate HMO-PPO) and Blue Preferred-Primary Plan (*future* Tristate HMO-POS). We regret to inform you that we are unable to offer you participation in the above referenced networks at this time due to the following:

* Network development and maintenance is a dynamic process. Currently, our managed care networks meet the needs of the memberships, thus Anthem is unable to accommodate your request for an application.

Thank you for your interest in Anthem.

Sincerely,

Anthony L. Firmstone, CHE
Executive Director

TLF/dp

Anthem Blue Cross and Blue Shield
2400 Market St.
P.O. Box 2700
Youngstown, OH 44507-0700

Anthem

March 7, 2001

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Anthony N. Pannozzo, M.D.
Physiatrist Assoc. of Youngstown
1419 Boardman Canfield Rd. #500
Youngstown, OH 44512

RE: 341052829-2A11

Dear Dr. Pannozzo:

Anthem Blue Cross and Blue Shield ("Anthem") has received copies of several letters that you have circulated to Youngstown providers. The letters include incorrect information and are disparaging to Anthem. Anthem considers these activities to be seriously damaging to our relationships.

If you do not cease and desist immediately, Anthem will investigate all legal avenues, including, but not limited to, actions for defamation, breach of contract and ethical violations, and we will pursue termination of your participation in Anthem's Traditional network.

Sincerely,

Anthony L. Firmstone, CHE
Executive Director

TLP/dp

[redacted]

Anthem Blue Cross and Blue Shield
2400 Market St.
P.O. Box 2709
Youngstown, OH 44507-0709

PLAINTIFF'S EXHIBIT "C"

Anthem

March 19, 2001

Anthony N. Pannozzo, M.D.
748 Boardman-Canfield Rd.
Boardman, OH 44512

Dear Dr. Pannozzo:

Thank you for your interest in Anthem Blue Cross and Blue Shield's Community Choice (POS), Community Preferred Health Plan (CPHP), Preferred Medical Plan (PMP), Anthem Senior Advantage (ASA), Blue Access (*future* Tristate HMO-PPO), Blue Preferred-Option Plan (*future* Tristate HMO-PPO) and Blue Preferred-Primary Plan (*future* Tristate HMO-POS). We regret to inform you that we are unable to offer you participation in the above referenced networks at this time due to the following:

* Network development and maintenance is a dynamic process. Currently, our managed care networks meet the needs of the membership; thus Anthem is unable to accommodate your request for an application.

Thank you for your interest in Anthem.

Sincerely,

Anthony L. Firmstone, CHE
Executive Director

TLF/dp

PLAINTIFF'S EXHIBIT "D"

Anthem Blue Cross and Blue Shield
2400 Market St.
P.O. Box 2709
Youngstown, OH 44507-0709

Anthem

March 7, 2001

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Anthony N. Pannozzo, M.D.
Physiatrist Assoc. of Youngstown
1419 Boardman Canfield Rd. #500
Youngstown, OH 44512

RE: 341052829-2A11

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Sincerely,

Anthony L. Firmstone, CHE
Executive Director

TLP/dp